Health Reform in the States

by

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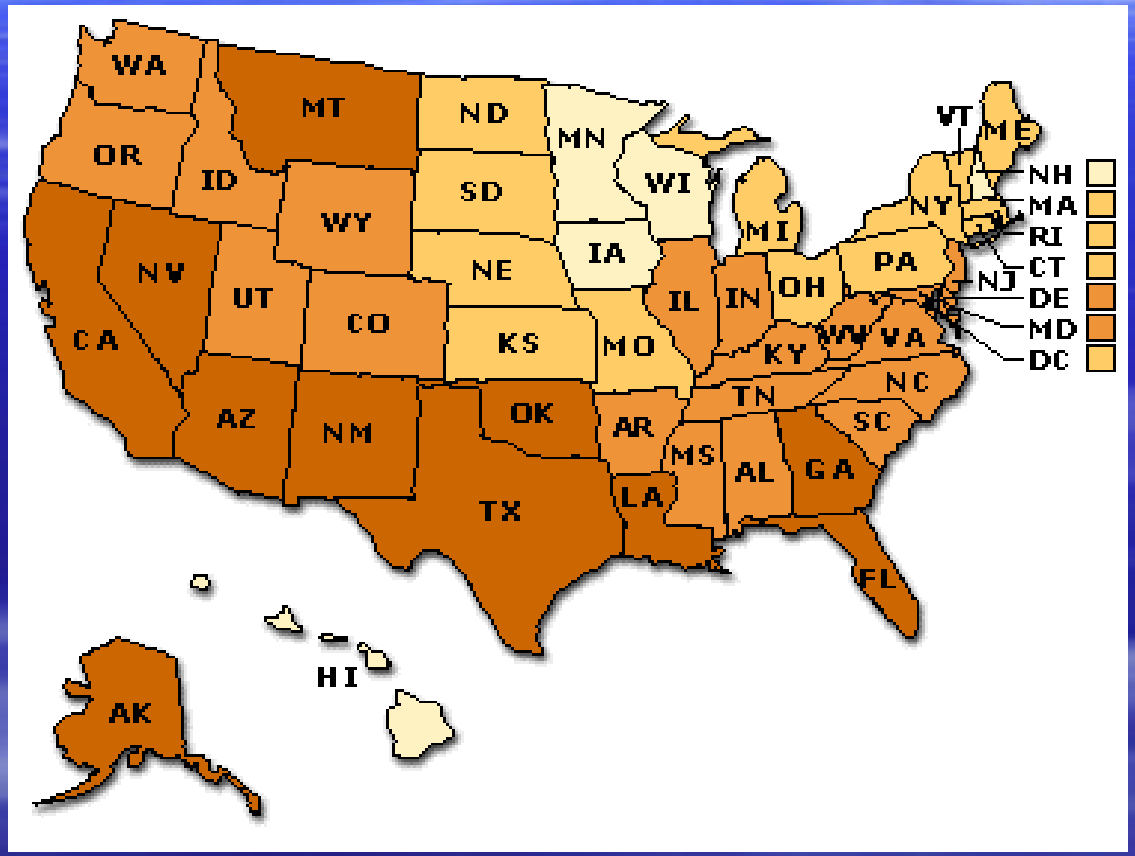
Coverage Rates
Total Population Uninsured, 2004-2005



- Less than 11%
- 11% to 13%
- 14% to 17%
- More than 17%

US average: 16%

Average over 2-years Source: US Census on www.statehealthfacts.org

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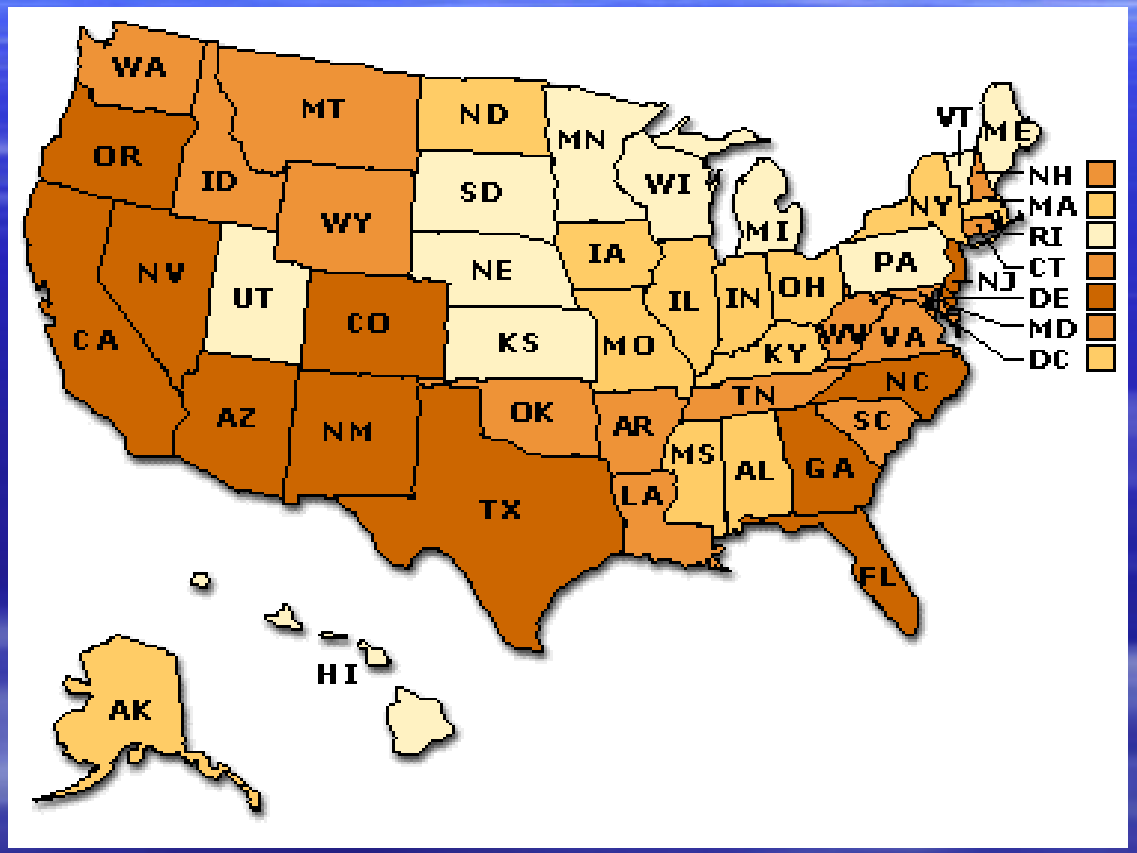
Near Poor: Uninsured Rates for the Non-elderly 100-199% Federal Poverty Level (FPL), 2004-2005



- Less than 23%
- 23% to 26%
- 27% to 30%
- More than 30%

Source: www.statehealthfacts.org

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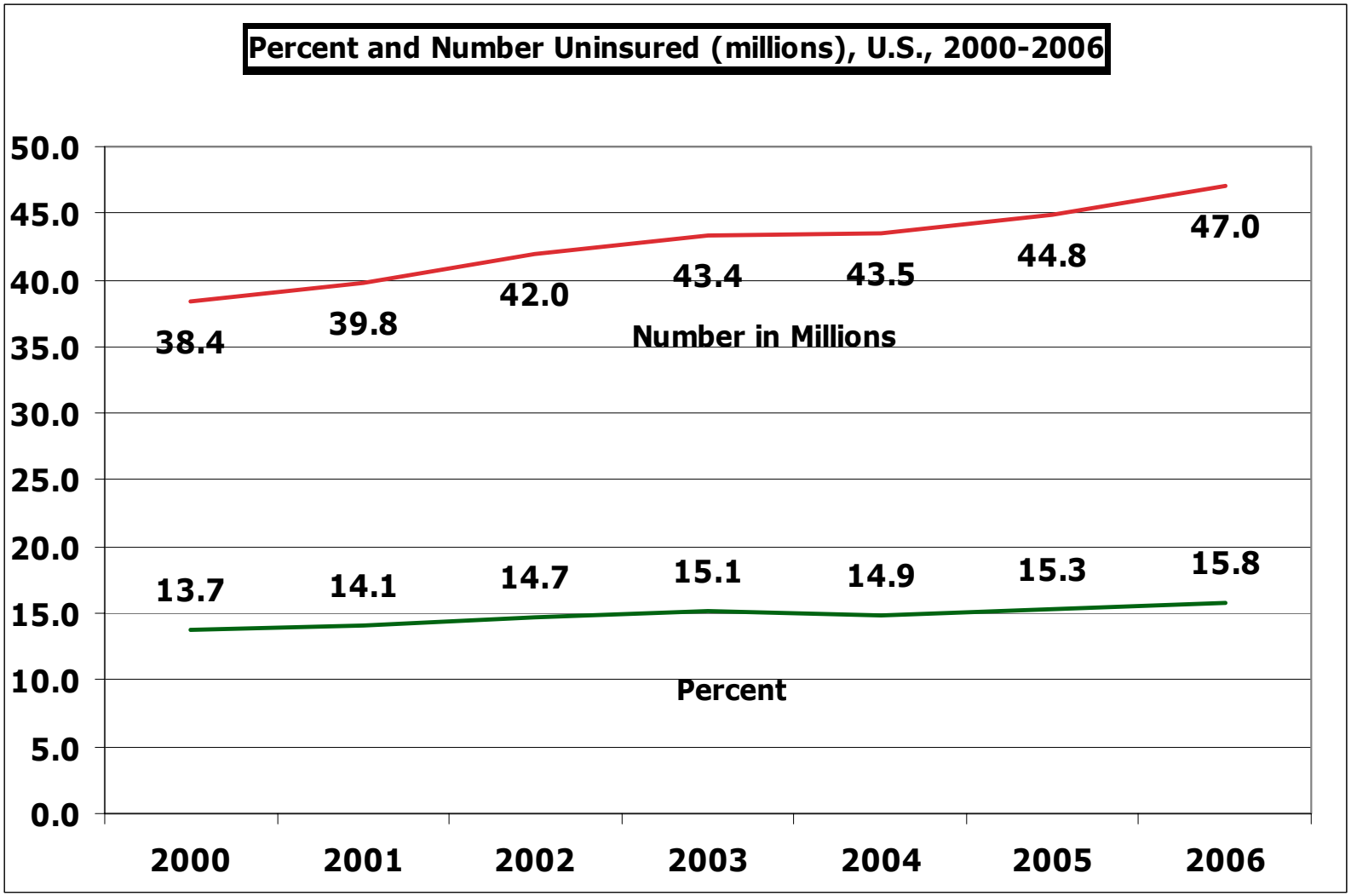
Persistent increase in uninsured



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Recent State Actions/Proposals

- Reduce the number of uninsured
- Focus on quality initiatives
- Focus on appropriate care for chronic disease
- Focus on prevention and wellness initiatives
- Concurrent focus on cost containment

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Reduce the number of uninsured…

By making health insurance more affordable.

- Exchanges/Connectors and Section 125 plans
- Premium Assistance
- Subsidize health insurance for the poorest people.
- Reinsurance (at least 7 states)
- Mandate light/limited benefit plans (at least 13 states)
- High Risk Pools (at least 33 states)
- Pooling
- Premium caps

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The "Connector"/Health Insurance Exchanges

- Exchanges/Connectors and Section 125 plans
  - MA, WA - connectors
  - RI, MO - mandatory 125 plans
- Central part of the Massachusetts 2006 health reform.
- Concept: provide a single place for persons to purchase insurance coverage (also very involved in the regs and implementation).
- Allows for greater transparency or competition and for pre-tax dollars to be used for the purchase of individual insurance coverage (section 125 plans).

- A number of states are now examining this in '07, including **CA, CT, MD, MI, MN, OR, PA**
- **RI and MO** enacted separate "cafeteria plan" requirement (per Dick's presentation)

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MA Connector

- 15,000 new purchasers via the Connector
- 165,000 newly insured (net growth in 6 plans)
- Insurers pay a premium fee of 4% to the Connector
- Market reforms: merger of small group and individual markets
  - 15% (minimum) decrease for individual plans
  - 1.4 % increase in small group premium cost

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Example:

Massachusetts Insurance Online sign-up

CommonwealthConnector

Welcome to the Health Connector!

LEARN. COMPARE. SELECT A HEALTH PLAN.

Big changes are happening in Massachusetts health care. Most adults must now carry health insurance. We give you the tools and the facts you need to find the right health plan.

We work to bring you

Your Connection to Good Health

Reduce the number of uninsured…

By requiring all residents to buy health insurance.

- Massachusetts requires every resident to have health insurance as of July 1, 2007 with some exceptions.
  - Affordability waiver; hardship waiver
- Question of affordability?
- Four state proposals/discussions also include individual mandate: CA, ME, OR, PA.

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Reduce the number of uninsured

By **involving employers in the financing of coverage programs**

- MA and VT are implementing employer assessments to help finance reforms. $295 and $395 per uninsured employee annually.
- 6 states currently are considering/discussing proposals that would tax or assess employers based on the health benefits offered to employees.
- ERISA ??

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Reduce the number of uninsured…

by assisting employees/employers in the purchase of health insurance (premium assistance).

This strategy leverages state contributions with employer and employee dollars

- Medicaid partnership: such as AR, IA NM, OK, TX (legislation passed/need waiver)
  - **Oklahoma** (O-EPIC) voluntary participating employers with 250 or fewer employees must contribute 25% of premiums; the state funds 60% of the insurance costs; employee pays the remaining 15%.
  - **New Mexico** - Employers are expected to contribute $75 per employee per month, and employees pay premiums up to $35 per month and copayments

Reduce the number of uninsured

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Non-Medicaid programs:

- MT: created a new small business purchasing pool--The State Health Insurance Purchasing Pool. Insurance subsidized on a sliding scale. Tax credits to small business currently offering. Program funded by a tobacco tax.
- Healthy New York reinsurance program.
- Cover TN: market based public/private partnership for small employers and uninsured workers with incomes below 250 % of FPL. Basic, major medical coverage for $150/month. Cost shared equally by the individual, employer, and state government. **Tennessee** tripled its tax on cigarettes to produce $239 million in new revenue for Cover Tennessee in FY 2008.

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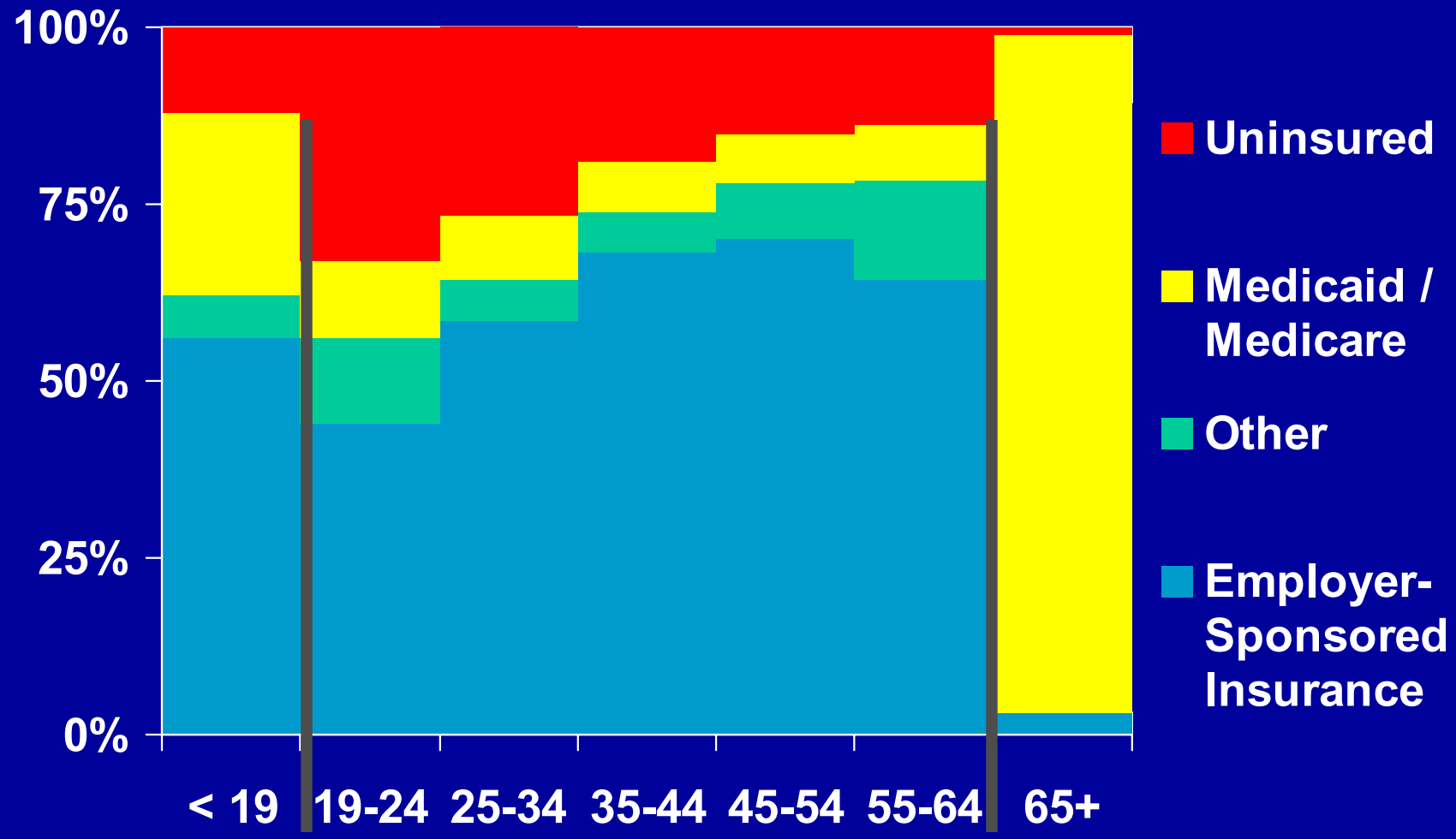
Distribution of Health Insurance Coverage by Age



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Source: 2006 CPS

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Reduce the number of uninsured…

by allowing young adults to remain on their parent or guardian's insurance longer.

- Fastest growing segment of the uninsured.
- Beyond the typical age-out of 19. Most laws cover up to age 25. NJ goes up to 30.
- Several health reform proposals being considered in the states include this strategy.
- Impact to date?
- State examples include CO, DE, ID, IN, ME, MA, MD,MN, MT, NH, NJ, NM, RI, UT, WA, WV.

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Reduce the number of uninsured…

by expanding or leveraging Medicaid/SCHIP.

- Medicaid expansions in MA and VT are foundation for universal coverage.
- Pro: federal dollars help to pay (63% match in IA)
- Con: must follow federal rules but with new flexibility
- Many 2007 proposals include expansions for the poor including CA, IL, IN, PA for adults.
- Discussing or implementing expanding SCHIP/Medicaid for kids: include CA, FL, HI, IL, KS, MD, MA, MN, MT, NY, ND, OK, OR, PA, TN, TX, VT, WA, WV and WI .

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CMS Clarified Regulations for SCHIP Expanding Eligibility

To prevent crowd-out CMS will expect that, for States that expand eligibility above an effective level of 250 percent of the FPL, the specific crowd-out strategies should include:

- Imposing waiting periods between dropping private coverage and enrollment
- Imposing cost sharing in approximation to the cost of private coverage;
- Monitoring health insurance status at time of application;
- Verifying family insurance status through insurance databases; and/or
- Preventing employers from changing dependent coverage policies that would favor a shift to public coverage.

SCHIP, Anti Crowd-out Provisions Continued

Other Requirements:

- **Assurance that the State has enrolled at least 95 percent of the children in the State below 200 percent of the FPL who are eligible for either SCHIP or Medicaid (including a description of the steps the State takes to enroll these eligible children)**
- Assurance that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five year period
- Assurance that the State is current with all reporting requirements in SCHIP and Medicaid and reports on a monthly basis data relating to the crowd-out requirements

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Enroll those that are eligible:

- Nationally almost three-fourths of uninsured children are eligible for, but not enrolled in public programs.
- Many people who qualified for Medicaid believed that they earned too much to apply.
- Most people stated if they qualified for the public program and the enrollment procedure was simple, then they would enroll their family.

Reaching Uninsured Parents: Insights about Enrolling Uninsured, Low-income Parents in Medicaid and SCHIP, a focus group study. Covering Kids and Families, Lake, Snell, Perry and Associates

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Reduce the number of uninsured

By increasing tax credits to residents/employers

- California option: Households up to 350% FPL would be eligible for a refundable, "advanceable" tax credit of up to $7,000 per family that could be applied to individual or employer-sponsored health coverage.
- Montana increased the tax incentives for small employers already offering insurance.

By increasing provider fees/taxes to help pay for subsidized insurance

- CA: Governor's Plan: **2% fee on physician revenues + 4% fee on hospital revenues**

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Re-cap on Funding Examples

1. Maximize Medicaid and SCHIP matching funds (expansion, realignment, 1115 waivers)
2. Maximize federal tax benefits (Cafeteria plans, tax credits)
3. Dedicate tobacco tax increase.
4. Require employer contributions.
5. Require enrollee contributions, co-pays.
6. Use provider taxes or assessments.
7. Use general funds.
8. Use other dedicated state revenue (lottery, tourist taxes, tolls).
9. Realistic reductions in costs (reduce medical errors, inefficiencies, negotiated & pooled group insurance & provider rates)

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Focus on quality

- Most new laws, bills and proposals address quality improvements.
- Maine Quality Forum - This group advocates for quality care and helps people make informed health care choices. Reports to consumers and the Legislature.

  Web site is http://www.mainequalityforum.gov
- Minnesota has several state initiated groups working on quality including the Minnesota Smart Buy Alliance: A joint effort between state government, labor unions, and private business to improve quality and lower costs.
- PA proposal to reduce hospital acquired infections and hospital medical errors.
- At least 4 states (NJ, PA, VI, CO) recently announced/passed measures to reduce disparities in health/health care.

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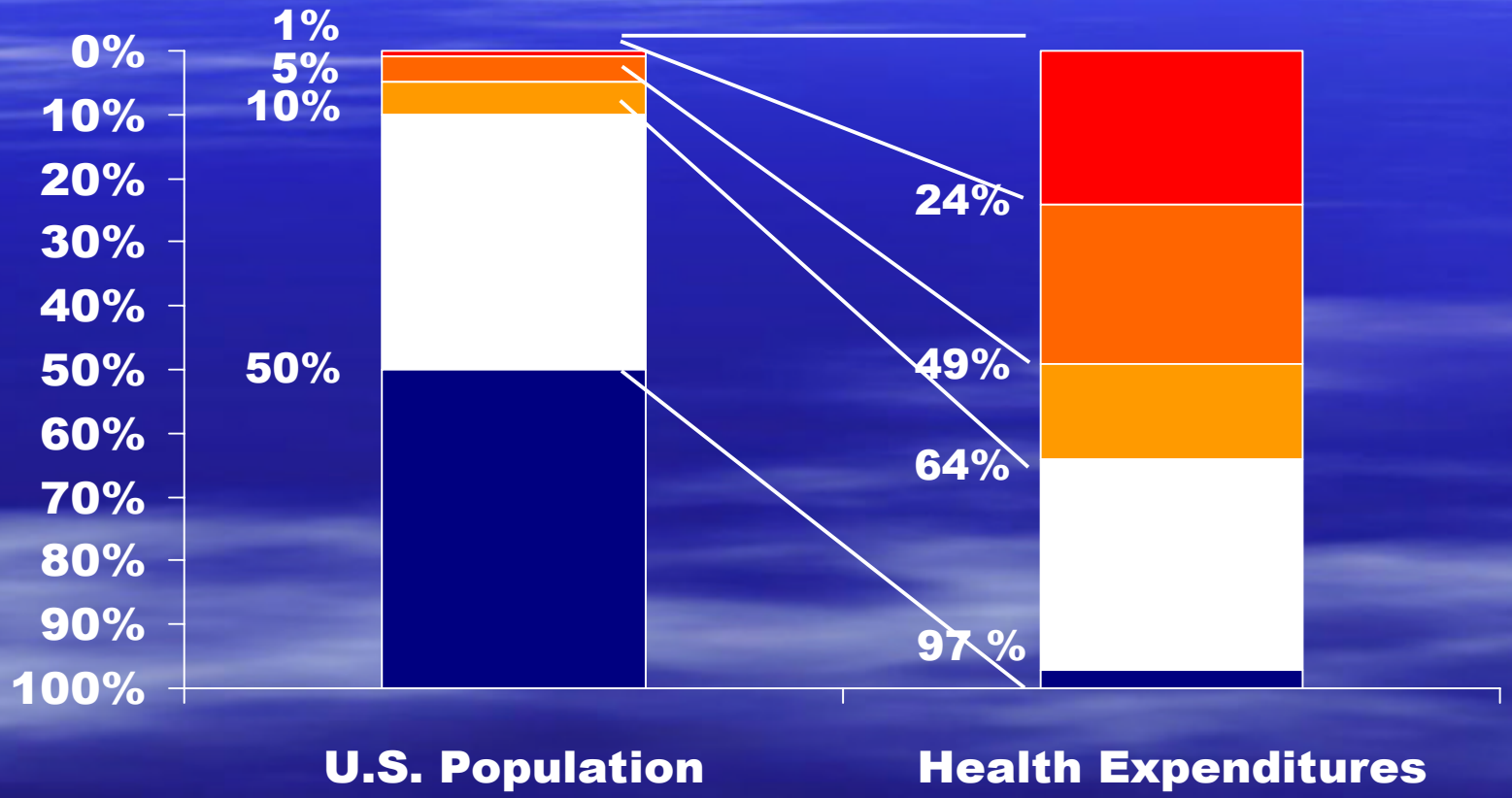
Focus more attention on management of chronic disease.

- 5% of the population has the greatest impact on cost.
- Sickest 10% account for about 65% of expenses.
- At least 7 of the 2007 proposals include aggressive programs to improve management of chronic disease.
- VT Blueprint on Health
  - Establish a system of chronic care management.
  - Change provider reimbursement system to encourage excellence in chronic disease management.
  - Waiving co-pays for patients who seek appropriate care.
  - Implement community programs.
- PA established a Governor's Chronic Care Management, Reimbursement and Cost Reduction Commission in May 2007.

Health Care Costs Concentrated in Sick Few:

Sickest 10 % Account for 64 % of Expenses

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 2003



Source: S. H. Zuvekas and J. W. Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, Jan./Feb. 2007 26(1):249–57.

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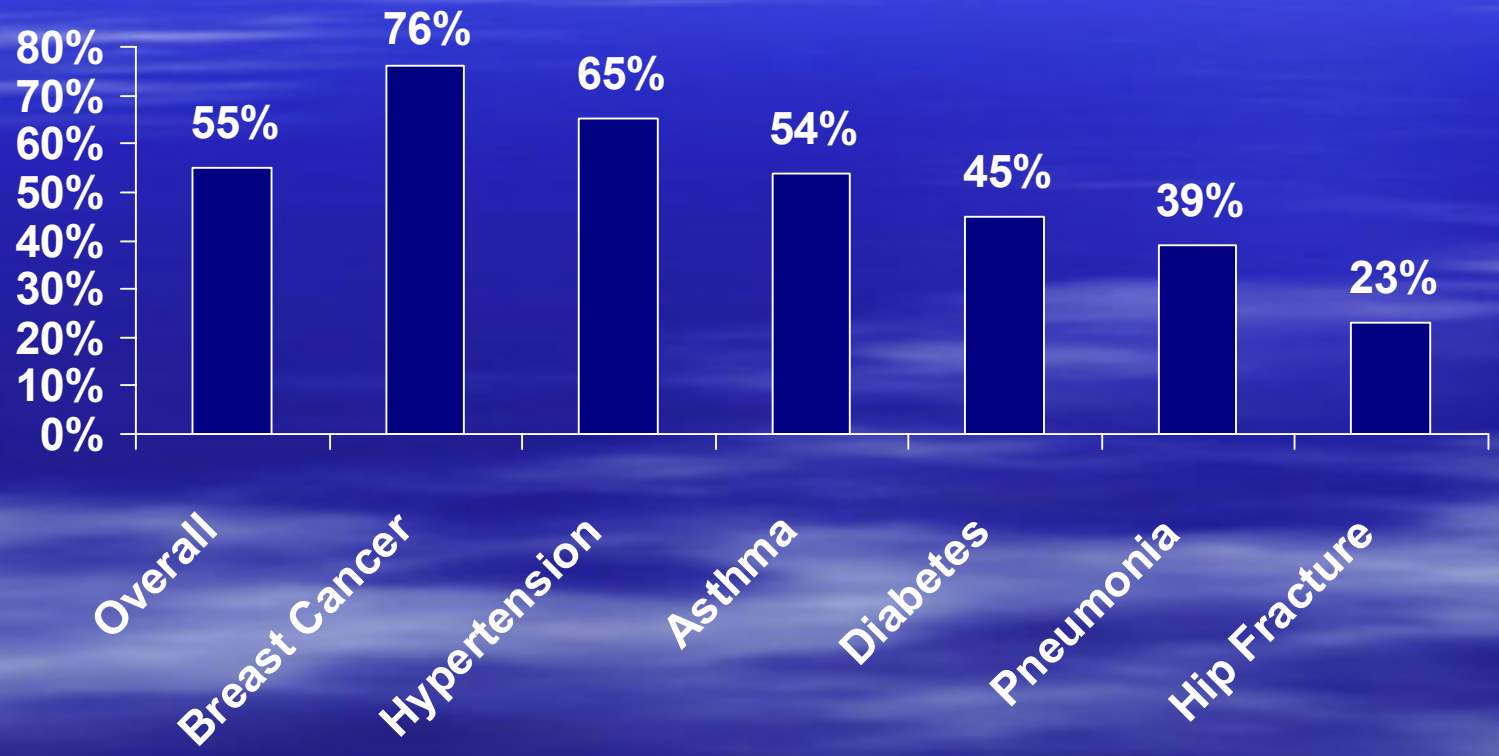
Percentage of U.S. Adults who Receive Recommended Care for their Conditions



Source: Elizabeth McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," The New England Journal of Medicine (June 26, 2003).

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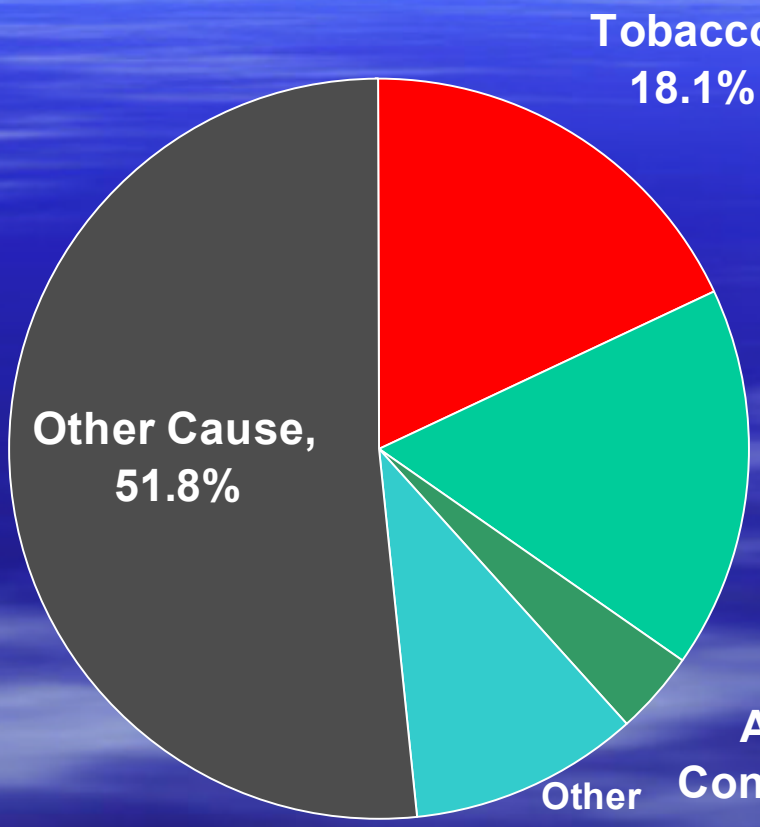
Focus on prevention to decrease the incidence of disease.

- Almost all 2007 health reform proposals/bills include prevention strategies and policies.
- Stand alone bills/laws to reduce trans fats in foods, smoking in public places and smoking in cars with children present.
- More emphasis on reducing obesity and increasing exercise.
  - Health related spending on obese people accounted for 27% of overall health spending increases between 1987 and 2001
  - 38% of diabetic spending
  - 41% of heart disease spending

Causes of disease



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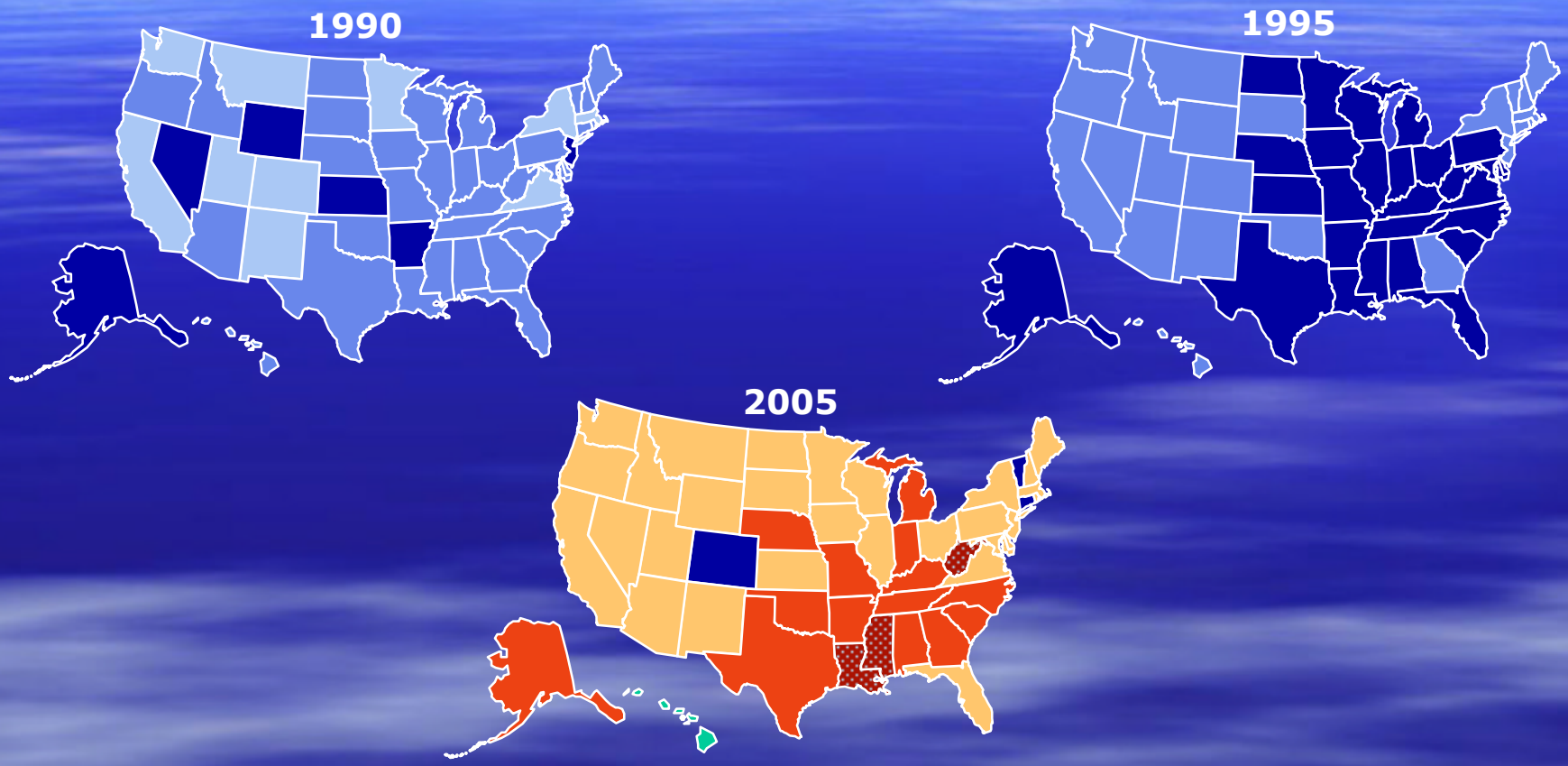
Obesity Trends* Among U.S. Adults

BRFSS, 1990, 1995, 2005

(*BMI ≥30, or about 30 lbs overweight for 5'4" person)



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Focus on wellness/personal responsibility in private and public insurance.

- Legislation in several areas to promote wellness: allowing premium discounts/rebates, employer tax credits, focusing on state employees, creating state-wide wellness programs.
- Workplace based health promotion programs may save an average of $3.50 for every dollar spent.*
- New law in Rhode Island created WellCare. An affordable health insurance product focused on primary care, prevention and wellness, actively manage chronic illnesses, use evidence based care in the most appropriate setting.
  - http://www.dbr.state.ri.us/documents/divisions/healthinsurance/060921_WCAC_WellCare_Issue_Brief.pdf

*Matthew Grawitch, Organizational Studies Program, St. Louis University, 2007

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Medicaid Reforms: A Shift Toward Consumer Responsibility and Prevention

- Health Opportunity Accounts
- Personal Responsibility
- Focus on Prevention
- Increased Cost Sharing

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Access to Health Care: Community Health Centers

- Health centers provide care for some 15 million people at 5,000 different locations.
- More than 40 percent of the patients who use these facilities are uninsured, and 36 percent are Medicaid recipients.
- In 2006, 36 states directly funded health centers for a total of $365 million.
  - In Arizona, a Community Health Center Special Line Item funds competitive grants for health centers. Using a mix of general fund money and federal grants, the state provided $11 million for health centers in 2006.
  - Indiana and Nebraska are among the states that use tobacco settlement funds to support health centers. Other states, such as California, Colorado, Michigan and Washington, earmark a portion of the state tobacco tax for public health programs, including health centers.
  - New Jersey funds health centers through a hospital assessment fund.

Access to Health Care: Incentives for Doctors to Practice in Underserved Areas

- **Federal** National Health Service Corps Scholarship Program and National Health Service Corps Loan Repayment Program
- **Forty-five** states have loan repayment programs for doctors who practice in underserved and/or rural areas. (Some programs are funded completely with federal dollars, while others use state and private dollars too.)
  - **The California Physician Corps Loan Repayment Program** encourages recently licensed physicians to practice in underserved locations in CA. The state will pay their educational loans, up to $105,000, in exchange for service in a designated underserved area for a minimum of three years.
  - **Arizona** has loan repayment programs for obstetrical practitioners serving in underserved areas. Also have a program for rural primary care provider.

Increasing Access to Health Care: Scope of Practice

- At least 9 states considered changing "scope of practice" laws
  - In Illinois, (HB1885) "The Retail Health Care Facility Permit Act" addresses many aspect of licensure of retail health care. Specifically, it limits the number of RNs and PAs a MD may oversee. (In Committee)
  - In Texas (HB 1096), they are reducing restrictions on MD oversight on RNs (Passed out committee, was not taken-up in House)
  - In Pennsylvania, as part of the Governor's Health Reform plan, there are multiple "scope of practice" bills pending: H.B. 1250-- "Scope of Practice" for Pharmacist, H.B. 1253-- "Scope of Practice" for certified registered nurse practitioners; and providing for professional liability. H.B. 1251-- "Scope of Practice" for Physician assistants.

Questions?

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